

116TH CONGRESS
2D SESSION

H. R. 7695

To require the Secretary of Health and Human Services to collect, analyze, and report qualitative and quantitative data on the use of telehealth during the COVID–19 public health emergency.

IN THE HOUSE OF REPRESENTATIVES

JULY 21, 2020

Mr. CURTIS (for himself, Mr. WELCH, and Ms. SHERRILL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To require the Secretary of Health and Human Services to collect, analyze, and report qualitative and quantitative data on the use of telehealth during the COVID–19 public health emergency.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “COVID–19 Emergency
5 Telehealth Impact Reporting Act of 2020”.

1 **SEC. 2. DEFINITIONS.**

2 In this Act:

3 (1) COVID–19 PUBLIC HEALTH EMERGENCY.—

4 The term “COVID–19 public health emergency”
5 means the outbreak and public health response per-
6 taining to Coronavirus Disease 2019 (COVID–19),
7 associated with the emergency declared by the Sec-
8 retary on January 31, 2020, under section 319 of
9 the Public Health Service Act (42 U.S.C. 247d), and
10 any renewals thereof and any subsequent declara-
11 tions by the Secretary related to COVID–19.

12 (2) SECRETARY.—The term “Secretary” means
13 the Secretary of Health and Human Services.

14 **SEC. 3. DATA COLLECTION AND REPORTS ON THE USE OF**
15 **TELEHEALTH DURING THE COVID-19 PUBLIC**
16 **HEALTH EMERGENCY.**

17 (a) DATA COLLECTION AND ANALYSIS.—

18 (1) IN GENERAL.—Beginning not later than 30
19 days after the date of enactment of this Act, the
20 Secretary shall collect and analyze qualitative and
21 quantitative data on the impact of telehealth serv-
22 ices, virtual check-ins, digital health, and remote pa-
23 tient monitoring technologies on health care delivery
24 permitted by the waiver or modification of certain
25 requirements under titles XVIII of the Social Secu-
26 rity Act (42 U.S.C. 1395 et seq.), and any regula-

1 tions thereunder, pursuant to section 1135 of such
2 Act (42 U.S.C. 1320b–5) during the COVID–19
3 public health emergency, which may include the col-
4 lection of data regarding—

5 (A) health care utilization rates across the
6 Medicare program under title XVIII of the So-
7 cial Security Act (42 U.S.C. 1395 et seq.) for
8 individuals confirmed or suspected to have
9 COVID–19 and individuals seeking care unre-
10 lated to COVID–19, including—

11 (i) patient access to telehealth services
12 in medically underserved communities; or

13 (ii) individuals receiving telehealth
14 services through federally qualified health
15 centers (as defined in section 1861(aa)(4)
16 of the Social Security Act (42 U.S.C.
17 1395x(aa)(4)) or rural health clinics (as
18 defined in section 1861(aa)(2) of such Act
19 (42 U.S.C. 1395x(aa)(2))) serving as origi-
20 nating sites or distant sites, and any chal-
21 lenges for providers furnishing telehealth
22 services in these communities;

23 (B) health care quality for individuals con-
24 firmed or suspected to have COVID–19 and in-

1 individuals seeking care unrelated to COVID–19
2 as measured by—

3 (i) quality of care metrics, such as
4 hospital readmission rates, missed appoint-
5 ment rates, or wellness visits, and

6 (ii) engagement metrics, such as vol-
7 untary patient satisfaction surveys and vol-
8 untary provider satisfaction surveys;

9 (C) audio-only telehealth utilization rates
10 when other video-based telehealth was not an
11 option or any other telehealth services that were
12 not provided in real-time (including text-mes-
13 saging or through online chat platforms), the
14 types of visits, and the types of providers treat-
15 ing individuals;

16 (D) telehealth utilization rates used to
17 treat individuals across State lines;

18 (E) the health outcomes of any individual
19 who utilizes telehealth services to treat an un-
20 derlying health condition such as diabetes, end-
21 stage renal disease, chronic lung disease, ob-
22 structive pulmonary disease, coronary artery
23 disease, or cirrhosis and the types of technology
24 utilized to receive care, including text-mes-

1 saging, online chat platforms, audio-only, or
2 video conferencing;

3 (F) the health outcomes of any individual
4 who utilizes mental health care and substance
5 use disorder treatment services, and the types
6 of technology utilized to receive care, including
7 text-messaging, online chat platforms, audio-
8 only, or video conferencing;

9 (G) the impact of State and Federal pri-
10 vacy and security protections on the delivery of
11 care and patient safety, including the security
12 of the various technologies utilized to deliver or
13 receive telehealth care;

14 (H) how telehealth access differs by race,
15 ethnicity, or income levels;

16 (I) the types of technologies utilized to de-
17 liver or receive telehealth care, including Zoom,
18 Skype, FaceTime, text messaging, online chat
19 platforms, or other technologies, as observed by
20 the Secretary, and utilization rates,
21 disaggregated by type of technology (as applica-
22 ble);

23 (J) the investments necessary for providers
24 to develop a platform to effectively provide tele-
25 health services to their patients, including the

1 costs of the necessary technology and the costs
2 of training staff; and

3 (K) any additional information determined
4 appropriate by the Secretary.

5 (2) BROADBAND AVAILABILITY DATA.—Upon
6 request by the Secretary, the Assistant Secretary of
7 Commerce for Communications and Information and
8 the Federal Communications Commission shall pro-
9 vide the Secretary any relevant data regarding the
10 availability of broadband internet access service (as
11 defined in section 801 of the Communications Act of
12 1934 (47 U.S.C. 641)) for the purposes of com-
13 pleting the report under paragraph (1).

14 (b) INTERIM REPORT TO CONGRESS.—Not later than
15 90 days after the date of enactment of this Act, the Sec-
16 retary shall submit to the Committees on Finance and
17 Health, Education, Labor, and Pensions of the Senate and
18 the Committees on Ways and Means and Energy and
19 Commerce of the House of Representatives an interim re-
20 port on the impact of telehealth based on the data col-
21 lected and analyzed under subsection (a). For the pur-
22 poses of the interim report, the Secretary may determine
23 which data collected and analyzed under subsection (a) is
24 most appropriate to complete such report.

1 (c) FINAL REPORT TO CONGRESS.—Not later than
2 180 days after the date of enactment of this Act, the Sec-
3 retary shall submit to the Committees on Finance and
4 Health, Education, Labor, and Pensions of the Senate and
5 the Committees on Ways and Means and Energy and
6 Commerce of the House of Representatives a final report
7 on the impact of telehealth based on the data collected
8 and analyzed under subsection (a) that includes—

9 (1) conclusions regarding the impact of tele-
10 health services on health care delivery during the
11 COVID–19 public health emergency; and

12 (2) an estimation for total Medicare spending
13 on telehealth services, including total spending for
14 each specific type of service for which Medicare re-
15 imbursement.

16 (d) STAKEHOLDER INPUT.—

17 (1) IN GENERAL.—For purposes of subsections
18 (a), (b), and (c), the Secretary shall seek input from
19 the Medicare Payment Advisory Commission, the
20 Medicaid and CHIP Payment and Access Commis-
21 sion and nongovernmental stakeholders, including
22 patient organizations, providers, and experts in tele-
23 health.

24 (2) COMMENT PERIOD.—For the purposes of
25 this subsection, the Secretary shall establish a com-

1 ment period not later than 14 days after the date of
2 enactment of this Act.

○